

Please complete this form and bring it with you to your intake appointment on _____ at _____ with Christine Psolka, Rm. 124, Library Bldg.
(date) (time) 732-255-0456

**Ocean County College
CENTER FOR ACADEMIC SERVICES
Disability Services (DS)**

Student Intake Form

Instructions: This form should be completed by the student. Please print all information except the essay (must be handwritten). The following information assists in determining appropriate disability services. **This information is not used in the OCC admissions acceptance process.**

General Information

Name _____ Date of Birth: _____

OCC Student No. (if known): _____ E-Mail Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Cell / Work / Other: (____) _____ - _____
(circle one)

How did you learn about the Disability Services/PASS Program? _____

Are you currently receiving the following benefits? ___ SSI ___ SSD

Are you working with the NJ Division of Vocational Rehabilitation? Yes ___ No ___
If so, name of your rehabilitation counselor: _____

Are you working with any other agency? Yes ___ No ___
If yes, name of agency: _____
Name of contact person: _____
Phone number: _____

What, if any, accommodations and/or academic adjustments do you think you will need for access to campus buildings and/or for your academic coursework? Please describe:

Medical Information

Have you ever had a serious medical or psychiatric diagnosis? Yes ___ No ___
If yes, please briefly describe: _____

Have you ever been hospitalized? Yes ___ No ___ Date(s): _____
If yes, please briefly describe: _____

Have you ever had an illness that has caused you to be absent from school for a long period of time? Yes ___ No ___
If yes, please describe: _____

Do you have any problems with the following?

Hearing	Yes ___	No ___
Vision	Yes ___	No ___
Mobility	Yes ___	No ___
Depression/Anxiety	Yes ___	No ___
Other _____	Yes ___	No ___

If yes, explain: _____

If you are currently receiving medical/psychiatric treatment, list the name and phone of doctor:

Educational Background

Name and location of high school: _____

Did you graduate from high school? Yes ___ No ___

If yes, what year? _____

If no, did you obtain a GED? Yes ___ No ___ If yes, what year? _____

Did you attend vocational school? Yes ___ No ___ If yes, what year? _____

If yes, program of study: _____

Have you ever attended college? Yes ___ No ___

If yes, name of college: _____

Dates of attendance: _____ Number of credits: _____

Why did you leave? _____

Work Experience

Are you currently employed? Yes ___ No ___ If yes, how many hours per week? _____

If yes, please briefly describe where you work and your duties:

What jobs have you held in the past? _____

What is your career goal? _____

Enrollment Information: ___ I have been attending OCC since _____(date).

___ I plan to start OCC on _____(date).

___ I am returning to OCC. I last attended on _____(date).

Checklist: *Thinking back over your years in school, have you had trouble in any of the following areas? Check all that apply:*

- Reading:**
- Poor Phonics
 - Slow reading rate
 - Problems understanding what is being read
 - Difficulty finding important points or main ideas
 - Confusion between similar words
 - Difficulty remembering what was read

- Writing:**
- Frequent spelling errors
 - Letter reversals
 - Overly large handwriting
 - Slow writing rate
 - Difficulty with sentence structure or poor grammar
 - Difficulty copying from board
 - Poorly formed letters or difficulty with spacing
 - Difficulty with capitals or punctuation
 - Compositions lacking organization and development of ideas

- Math:**
- Problems with reasoning and abstract concepts
 - Difficulty recalling arithmetic operations
 - Problems remembering math facts
 - Confusion or reversal of numbers, number sequences or math symbols
 - Difficulty reading or understanding word problems
 - Copying problems and difficulty keeping columns of numbers in line

- Spoken Language:**
- Poor ability to remember or understand spoken instructions
 - Difficulty expressing ideas or thoughts out loud
 - Problems describing events or stories in proper sequence
 - Greater problem with grammar or ideas when speaking than when writing

- Study Skills:** _____ Poor organization and management of time
_____ Difficultly beginning and sticking with study/projects
_____ Poor note taking and outlining skills
_____ Problems finding and using information from different sources
_____ Difficulties and/or anxiety with taking tests
_____ Poor memory and low ability to recall studied material
_____ Problems with attention and concentration

- Social skills:** _____ Difficultly “reading” other people; understanding body language and facial expressions
_____ Problems interpreting or understanding subtle messages such as sarcasm, teasing, banter, or jokes
_____ Confusion relating to time, directions or visual motor coordination
_____ Inability to perform well at sports or games
_____ Poor judgment leading to behavioral problems
_____ Feelings of rejection due to learning problems
_____ Talking out of turn or too loudly

Your signature: _____

Date: _____

Essay on page 5 is required.

